IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
NORTHERN DIVISION

CHARLES SLAUGHTER

PLAINTIFF

V. CIVIL ACTION NO. 3:20-CV-789-CWR-FKB

DR. DANIEL P. EDNEY, IN
HIS OFFICIAL CAPACITY AS
THE MISSISSIPPI STATE
HEALTH OFFICER, ET AL.

DEFENDANTS

30(b)(6) DEPOSITION OF MISSISSIPPI STATE DEPARTMENT OF HEALTH {DR. LUCIOUS LAMPTON}

Taken at the instance of the Plaintiff at Mississippi Attorney General's Office, 550 High Street, Jackson, Mississippi 39205, on Friday, December 20, 2023, beginning at 9:09 a.m.

REPORTED BY:

ROBIN G. BURWELL, CCR #1651

to advise what we do. We've attempted to address every issue that's been brought to us about problems that people are having and bring it before our committee. And usually we set up a task force to deal with that.

Such issues, as we've had issues with some counties not having dialysis units, and we've brought the -- we have a subcommittee that deals with renal CON, and we've discussed ways to try to provide better access to care.

Probably in about 2009 the Board voted to -- the primary role of CON, historically, had been to control monitary spending by the government in a big way, was one of the impetuses for its creation. At the Department we've seen it has -- it can help us with health planning and that we can use it as a vehicle to protect essential institutions and also try to further their access to care in the state. So we made access to care as one of the missions of CON in Mississippi and officially included it in its mission.

And I start every meeting by talking about that we're here to protect the interests of the citizens of the state. And I think if we can

were lifted there would be a significant need to look at that. And when you were answering my question, you said that you weren't sure if the need would change. And I think you meant the patients need for home health may not change based on what the moratorium does; is that right?

A. Right. We may -- if the moratorium is lifted and then we sort of focus in perhaps a little bit more laser-like on need and are we assessing it correctly. Which we're doing any way, but we may not have looked at, you know, in the most recent period.

I mean, from my personal experience and from talking with staff, I doubt there's going to be a need for more home health services in the state based on that. It's just the health care environment doesn't really seem to need that right now because there is a retraction in demand for home health services compared to a decade ago.

Q. Yeah. The reason I asked that is I just wanted to make sure my question was clear. What I want to ask is regardless of whether the need itself changes, the Board would look at the criteria that applied to home health agencies, that they had to meet in order to get a CON. And

on Page 2?

A. I just don't want to go to Table 10.

Q. We're almost done with the tables.

Do you see that it also totals the number of patients who were denied a referral to home health agency?

A. Total referrals -- yes.

Q. Okay. And do you see above the totals in the descriptions of these we see that in the 2020 report on home health agencies it reports that there were 811 patients who were denied a referral because the needed service was unavailable. Do you see that?

A. Needed service unavailable, total 811, yes.

Q. And then there's also a list for other and it's 14,633. Is that right?

A. Correct.

Q. Okay.

A. That's a relatively large number of other. But there are a lot of others.

Q. Is the Board of Health -- they're conducting a review of the State Health Plan and certificate of need process in Mississippi right now?

A. Correct.
Q. Okay.
A. HMA is doing a very extensive study that may even go over years.
Q. Is it right that there's kind of two different pieces of that, as I understand it? And I'll just say one being kind of correcting, or more about the State Health Plan itself and the data it uses and the methodologies and things like that, and then maybe another --
A. You are correct. You know, we're trying to see -- we're trying to make the State Health Plan -- there is a desire to make it a more strategic proactive document. So we can better inform the legislature and the leadership about the needs of the state regarding health.
And then also it needs to be a more -- I'm not going to say -- we're looking at the regs and what's in the State Health Plan to try to be sure that we have policies that review need criterion and that they're up-to-date with where they need to be for 2023 and 2024 instead of 2000.
Q. Okay.
A. And, you know, and oftentimes you get a need criteria and it remains unchanged for long

periods. And we're very much feeling that if we're going to have CON, it needs to be a vital document in our State Health Plan. Certainly needs to be a vital document and that we need to do updates with need criterion and we need to do updates with what needs CON and things that may not even need the CON any more.

Q. That review of the need criterion that is being conducted, does that include for home health agencies?

A. Yes.

Q. Okay. Do you know how -- first of all, was this done using an appropriation from the legislature to provide additional funds to conduct these reviews and overhauls?

A. Yes.

Q. Do you know how that came about? Who was the first person who said to you that there was going to be a review of the State Health Plan and CON program?

A. I do not remember. I think we have been talking -- the CON committee has been talking for several years about the need to have outside consultants come and give us direction and expertise.

On the Board of Health, Jim Perry has taken an outstanding role in encouraging us to do this. But there are others, and there are legislative leadership that's very interested in this. But I don't remember the first person that I've discussed. But I think there's significant discussion, certainly probably going to occur at this legislative session about the CON process, its relevance in going forward, do we need to keep it, do we need to get rid of it, do we need to get parts of it. As somebody who's worked with CON for an extended period, my advice for the legislative leadership and those in positions of power is that if we decide we're going to get rid of it, we probably need to get rid of it slowly and with a considered plan about how we do it, just not open the -- the barn doors open. We have a very fragile health system in the state, and it doesn't respond to stress and change very well. And even though market forces in the state play a significant role with health care, health care is different. There are essential institutions that have very low margins. The government and insurance payments often complicate those margins. Hospitals often have to have call centers that are

unrelated to their bread-and-butter services in order to provide the bread-and-butter services.

I mean, I kind of view medicine as a philanthropic enterprise that's working in a market system. And if you look at the history of medicine in the state, the state has been providing charity payments to hospitals for over a hundred years.

Q. I know from the -- I've watched the Zoom meeting of y'all's December 12th meeting about all of this. And I know that you plan to get an executive summary from the consultant soon, hopefully before the legislative session. Have you seen an early draft of that executive summary?

A. Outside of what was presented at the Board meeting, I have not seen a draft. Our hope is we have a Board meeting on the 10th of January, and they're supposed to provide us with that prior to that and prior to the legislative session which begins the 3rd, I believe. So the intent of the Board and the legislature in encouraging us to do this has been to have our consultants advise not only the Board, but the legislature about appropriate health needs, especially with CON and with the State Health Plan.

Q. And in that meeting, Dr. Edney also said that CON was definitely going to be a significant issue this session. Do you know what's prompted it to be an issue such that the Board of Health knows it will be an issue this session?

A. I've been told by legislative leadership that it's going to be an issue. In the last, I guess, two to three years a significant legislative and executive leadership have been expressing an interest in everything from moderating CON to a gradualism of getting rid of it to just an end to it. So to say it's a -- there seems to be a little bit more discussion about some definitive action with CON. In the past there would always be people that would want to do something with CON. But the stakeholders, the hospitals, the nursing homes, the home health agencies, most of the health infrastructure while there are headaches with CON, most of them feel like that it protects their ability to survive. And fragility of the system has been such that they've been able to keep things from happening. But I think there's certainly -- I'm not sure Libertarian would be the word, but I think there's a thrust in the legislature that feels like that a

market system without CON would be in the best interest of health care. Although as people start to talk about how that would evolve, it gets complicated. And as I stated, my thing is whatever -- it's a legislative decision. We have CON because of legislature, and they felt it was necessary. And it was a national thing for a period. I think what we've tried to do during my tenure on the Board of Health from 2007 is realizing the legislature was not going to get rid of it. We've tried to make it a functional system that was responsive to the needs of the patients, responsive to access to care and also responsive to the stakeholders and not creating burdensome hurdles. And if there were needs and problems in it, that we would try to address them and solve them in a way that was in the best interest of the citizens. And I think in most situations that's happened.

Dr. Courier(phonetic) used to talk to me about she was not real big on CON, but by the end of her term, she and I would talk about the benefits of CON with health planning. But it goes back to our State Health Plan and CON. If we're going to have it, we need to use it strategically

to assist essential services. And if it's not an essential service and if it doesn't need to be there, why do we have it. And so we need, you know -- it needs to be something that's vital and changing to the evolving health care market.

And some of the problems that we have and some of the restrictions are national problems and CMS issues and not just CON. And some of the things we think that are causing us restraints -- you know, physician ownerships of hospitals is a CMS or national issue. There's the Stark laws are all national. The health care system is extremely complicated as far as reimbursements. I have a lot of fear for survival.

As one -- Evan Dillard who was a friend of mine from -- he used to run Forrest General Hospital. He said the problem with the health care system is there's not enough money to go around to get the job done.

Q. On that review, y'all haven't settled on any recommendations to the legislature yet, I take it?

A. No, we have not.

Q. Okay.

(Exhibit 11 marked for identification.)

I've not had -- in my 30 years of practice had any problems referring anyone for home health service. The biggest problem with referrals usually involves insurance. And some home health agencies are not preferred providers, but most of the insurance companies have to have a preferred insurance -- I mean, a home health agency in an area. But sometimes their preferred home health agency may really not be as engaged -- may not be the leading home health agency in that area. And that's where patients, sometimes they want this other one, but their insurance allows one. But that's just the market system and the insurance companies at work. But that's usually been the only problem. And I think the problem that I've seen with home health agencies is the increased scrutiny that doesn't allow them to hold on to patients very long, that perhaps would benefit from an extended home health care course.

The comment was made home health care can keep a patient out of the nursing home and save the -- save our system, our health system money if its used appropriately.

Q. Okay. I want to talk for a moment about the circumstances under which the Board may make

recommendations to the legislature. I think I heard you make references to that. I'm trying to understand and get my arms around how it could come to be that the Board may make a recommendation from time to time to the legislature.

For instance, suppose an individual provider in the home health agency setting in this particular case, suppose someone came to the Department, to the staff and presented evidence that they met these number one and number two criteria that have been talked about here today. Suppose with the moratorium in effect, suppose the provider came and provided evidence to the staff at the Department that they met these criteria. They had the equivalent of 50 patients or more, you know, need, unmet need. Would you then -- in view of the moratorium, would you expect someone on the staff to at least report to you as chairman, you know, this development so that you can consider have -- have the Board consider whether to make a recommendation to the legislature?

MR. RICE: Object to form.

THE WITNESS: Yeah, the process would

be -- the staff, if somebody came to them with a request, and the staff felt like it was a worthy request, which that would be considered a worthy request, there would be need established. It would be brought to the CON committee that would vet it. And we'd probably get some experts to study it and then bring that to the full Board. Since it would require lifting the moratorium, it would have to be a legislative -- and usually -- I mean, we don't have a lot of legislative requests. We usually have about 10 bills, and a lot of them are formalities. So it's a rare thing for us to request the legislature to do something. Usually we're trying to respond to legislative requests or to fulfill our role without things going to the legislature. That would be certainly appropriate, it involves access to care. And if we felt like there was a need for more nursing home beds, if we felt like there was a need for more home health care that moratorium needed to be lifted, we would -- I would have no hesitation about recommending to the full Board, and they would be supportive of that, to the legislature to do that. But that would be done after we would do our homework. We would have -- we would probably get

a task force that would study the issue. But if the data is there and the facts are there, that's in the best interest of the citizens, and that's what we should be doing. And I think that would be -- we take it to the legislature. Now, would the legislature respond? Perhaps not, but perhaps so. But I think they would also have our research and the data to back that up.

Q. (By Mr. Davis) As we sit here today, has anyone reported to you in the home health agency, you know, arena, you know, specifically, that they've had third parties come make presentations that have led the staff to have a concern that they think they need to report to your committee that they perceive an unmet need?

A. This case is the first time I've heard of any discussion of unmet needs or unprovided services in the health care industry in Mississippi. Since 2006 I haven't heard anything.

Q. When you say "this case," you mean the fact that Mr. Slaughter has filed a lawsuit?

A. Correct.

Q. Okay. I mean, Mr. Slaughter, did he ever come to your staff and make a presentation showing them evidence that there is this -- that

So -- but to lift the moratorium that would require a legislative action. The legislature knew we had been discussing psychiatric bed need for a while.

Q. Do you recall if that was a recommendation that was part of the Board's legislative agenda that year, or if it was a suggestion that the Board just support?

A. I don't remember.

Q. Okay.

A. I think the CON explored it in supportive of it, but I'm not sure how it finally -- I'd have to look at the data to see how it worked out. But we had at least three or four meetings, and we had a task force.

Q. Mr. Rice discussed the recent study. As recently as last week, you guys had a Board meeting where some of these high level CON debates were held. Is that correct?

A. Oh, yeah. And we're getting expert consultants to advise us. They're not looking at just what we do, although we're focused, but what's being done around the rest of the country, what are trends going on in states that are retaining CON, how is it evolving. And in states

that have it that have taken it away, what have been the negative consequences and the positive consequences.

Q. Are there any two states that are exactly alike when it comes to CON retention, the purposes of CON. Are two states -- are there two states that are exactly alike or do they all differ, I think is my question?

A. It's frequently stated that CON regs are different in every single state. Mississippi has its CON and other states have their CON. What's on CON and what has moratoriums, what doesn't, what is mandated has a CON, the cost allowances for all of these things varies. So they're all very different.

I think what we share is -- and what we may have different than some is a poor population, a fragile health care system, and we have a population with extraordinary social determinants that are going to impact their ability to access care.

Really, it's about poverty. We are struggling, so the question with CON is does CON help us take care of our population in the best manner. And if it does so, I think we as a Board

of Health need to say we think that it does help with health planning and with health strategy, how can we make it more effective and less burdensome to the system.

Q. You talked earlier about the three full-time staff and three part-time staff that work at the CON division. And I was just going to ask you if you could maybe expound a little bit on the function of the moratorium with regard to the CON staff and how that moratorium actually assists the CON staff if you believe it does.

A. Well, anyone who works at our Department of Health realizes that we have significant problems with staffing. We don't have enough staff. The staff are often not extraordinarily trained. Basic competency is sometimes something we are very concerned about. Our most competent employees either move up or they're hired by somebody else. The Board has had extensive conversations with the personnel board and with the legislature about the need to pay our employees that do critical work more money and also to get them help.

I think when we look at some of the typos in some of the papers that we were looking

at, I think we're looking at a very overly worked staff that has a lot of -- we have three -- three full-time employees to do everything from hearings to evaluation to -- now they have a committee and they have other staff that do help, but largely, they're doing it all. So three full-time employees that are assisted by an administrative assistant and two part-time people.

The concern about -- you know, the reason to raise the moratorium or get rid of the moratorium would be that there would be a need for more home health. If there's not a need, then it would just be more work for my staff. From a purely selfish standpoint as a Department, I don't need to give my CON staff any work that's not essential for the public good, and it's not going to be acted on and gone forward with.

So we have a very lean staff, and I think -- and that's not going to change. So any unnecessary work I would not want for my Department. However, if there's a need there, we need to -- it would be something worthwhile for the Department.

Q. And if there was a need, if someone could show a need, demonstrate a need to the

come to a Board of Health meeting. Once they have the hearing, before we vote on something, we allow public comment to the Board. That was somewhat hampered by COVID, but public comment is allowed to address the issues that we're going to vote on.

Q. Let me just ask one last question and make sure I'm clear. You said earlier that other than this -- well, you said earlier that in your 40 years you've never heard from anyone that there is a need from additional home health agencies in Mississippi; is that correct?

A. I do have gray hair, but it's only been 30 years.

Q. 30 years. Thank you very much for your time.

A. It feels like more at times. But in my 30 years, I've never heard anyone say we need more home health agencies.

MR. SCHELVER: No further questions. Thank you for your time today.

(Time Noted: 4:00 p.m.)

SIGNATURE/NOT WAIVED

ORIGINAL: MR. RICE, ESQ.

COPY: MR. SCHELVER, ESQ.

COPY: MR. DAVIS, ESQ.

CERTIFICATE OF COURT REPORTER

I, Robin G. Burwell, Court Reporter and Notary Public, in and for the State of Mississippi, hereby certify that the foregoing contains a true and correct transcript of the testimony of LUCIOUS LAMPTON, as taken by me in the aforementioned matter at the time and place heretofore stated, as taken by stenotype and later reduced to typewritten form under my supervision by means of computer-aided transcription.

I further certify that under the authority vested in me by the State of Mississippi that the witness was placed under oath by me to truthfully answer all questions in the matter.

I further certify that, to the best of my knowledge, I am not in the employ of or related to any party in this matter and have no interest, monetary or otherwise, in the final outcome of this matter.

Witness my signature and seal this the 8th day of January, 2024.

ROBIN G. BURWELL, #1651
CRR, RPR, CCR

My Commission Expires:
April 6, 2025